

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/16/2024
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NAME OF PROVIDER OR SUPPLIER THE MEADOWS OF SARASOTA SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 18TH STREET SARASOTA, FL 34234
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A follow-up by desk review was conducted on 1/16/24 for The Meadows of Sarasota Senior Living, an assisted living facility in Sarasota, Florida. The follow-up was in response to the the change of ownership, health facility reporting system, emergency power plan, visitation monitoring and complaint survey completed on 9/26/23 and the revisit survey completed on 11/15/23. Based on the facility's plan of correction and supporting documentation, the deficiency was corrected as of 12/14/23.	{A 000}		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE